SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Filing at a Glance

Company: United Life Insurance Company

Product Name: LIU-113 (10-08)	SERFF Tr Num: UNFG-125859556	State: ArkansasLH
TOI: L07I Individual Life - Whole	SERFF Status: Closed	State Tr Num: 40593
Sub-TOI: L07I.111 Single Premium - Single Life	Co Tr Num: LIU-113 (10-08)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Joanne Young	Disposition Date: 10/22/2008
	Date Submitted: 10/17/2008	Disposition Status: Approved
Implementation Date Requested: 01/01/2009		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 10/10/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/22/2008	
State Status Changed: 10/22/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

LIU-113 (10-08) Application for Life Insurance

We are filing this updated applicaiton to be used with our life products. It will replace our current life app LIU-113 (3-07).

This filing to the best of our knowledge contains no unusual or possibly controversial items from normal company or industry standards.

Thank you for your consideration.

SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Joanne Young, Analyst
118 2nd Ave SE
Cedar Rapids, IA 52407-3909

jyoung@unitedfiregroup.com
(319) 286-2620 [Phone]
(319) 286-2570[FAX]

Filing Company Information

United Life Insurance Company
118 2nd Ave SE
PO Box 73909
Cedar Rapids, IA 52407-3909
(319) 399-5700 ext. [Phone]

CoCode: 69973
Group Code: 248

Group Name: United Fire Group
FEIN Number: 42-6061188

State of Domicile: Iowa
Company Type: Life

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Life Insurance Company	$20.00	10/17/2008	23257667

SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/22/2008	10/22/2008

SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
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Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/22/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Applicaiton for Life Insurance		Yes

SERFF Tracking Number:	*UNFG-125859556*	*State:*	*Arkansas*
Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: LIU-113 (8-08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LIU-113 (10-08)	Application/ Enrollment Form	Applicaiton for Life Insurance	Initial		0	LIU-113 (10-08).pdf

APPLICATION FOR LIFE INSURANCE
UNITED LIFE INSURANCE COMPANY

P.O. Box 73909 – Cedar Rapids, Iowa 52407
800-637-6318 FAX 888-728-9736

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is or may be guilty of a crime and may be subject to fines and confinement in prison."

PROPOSED INSURED A	PROPOSED INSURED B (Other insured)
Name _____	_____
Street Address _____	_____
City _____ State_____ Zip _____	_____
Soc.Sec. # _____ U.S. Citizen ❑ yes ❑ no	_____ ❑ yes ❑ no
Home Phone _____	_____
Date of Birth _____ Age_____ ❑ Male ❑ Female	_____Age _____❑ Male ❑ Female
Driver's License # _____	_____
Occupation_____	_____
Employer _____ Work Phone _____	_____
Other Life Insurance or Annuities in force? ❑ yes ❑ no $_____	❑ yes ❑ no $ _____
Have you smoked cigarettes in the past 12 months? ❑ yes ❑ no	❑ yes ❑ no
Used any tobacco/nicotine products in the past 24 months? ❑ yes ❑ no	❑ yes ❑ no
RATE CLASS	❑ Preferred ❑ Select ❑ Standard
❑ Standard (Cigarette smoker)	
❑ Select (No cigarettes for 12 months)	
❑ Preferred (Minimum $100,000 face amount. NOT available for SPWL. No tobacco or nicotine products for 24 months.)	

FACE AMOUNT $ _____

If face amount $1,000,000+, complete Large Amount Supplement

PLAN

(1) ❑ Uni-3 ❑ Level ❑ Increasing Cost of Living ❑ Yes
(2) ❑ Whole Life
(3) ❑ 20-Pay Whole LIfe
(4) ❑ Single Premium Whole Life

Guaranteed Insurance Option $_____
Number of Options (1-5) _____
Final Total Benefit $_____

(5) ❑ Annual Renew & Convert Term
(6) ❑ 5-Year Renew & Convert Term
(7) ❑ 10-Year Renew & Convert Term
(8) ❑ 20-Year Renew & Convert Term

RIDERS (availability by plan number)	Proposed Insured A	Proposed Insured B
❑ Other Insured Rider (1, 5, 6, 7, 8)	$ _____	$ _____
❑ Other Insured 20-Year Term (1, 2)	$ _____	$ _____
❑ Disability Income 2-Year Limited benefit (1, 2, 5)	$_____	$ _____
❑ Disability Income to 65 (1, 2, 5)	❑ 30 day ❑ 180 day $_____	❑ 30 day ❑ 180 day $ _____
❑ Disability Waiver (1, 2, 3, 5)	❑ Yes	❑ Yes
❑ Accidental Death (1, 2, 3, 5)	$_____	$ _____

Available to Insured A only

❑ UNI-3 Term Insurance Rider $_____
❑ UNI-3 Scheduled Increase Option $_____
❑ Whole Life Guaranteed Insurability Option $_____
❑ Children's Term Rider (1, 2, 5, 6, 7, 8) $_____

Owner _____ Tax ID/SS Number_____
Street Address _____ City_____ State_____ Zip _____
Phone Number_____ U.S. Citizen ❑ yes ❑ no
Contingent Owner (Required if proposed insured is a minor) _____

Payor Name (if different than owner)_____U.S. Citizen ❑ Yes ❑ No
Billing Address _____ City_____ State_____ Zip _____

Planned 1st Yr or Annual Premium $ _____ Payable: Bill ❑ Mo ❑ Qrtly ❑ SA ❑ Ann ❑ Single Premium
Additional lump sum $ _____ 1035(a) Exchange? ❑ Yes ❑ No List Bill: ❑ Mo ❑ Qrtly
Cash with app $ _____ Automatic withdrawal (EFT) ❑ Mo ❑ Qrtly Draft date_____
(Attach voided check.)

MEDICAL

	Proposed Insured A		Proposed Insured B	
1. (A) Ht. ____ ft. ____in. Wt_____ (B) Ht ___ft. _____in. Wt. _____				
2. Provide the name, address and phone number of your personal physician along with the date and reason last seen. Dr. Name _____ Phone _____ Address _____ Date and reason last seen: _____				
3. Has the proposed insured ever applied for or been examined for life, accident or health insurance that was declined or modified as to rate or amount? In Missouri only, has the proposed insured ever applied for or been examined for life, accident or health insurance that was modified?	Yes ❑	No ❑	Yes ❑	No ❑
4. Has the proposed insured ever had or been told by a medical practitioner that they had the following (In Indiana only, this is limited to the past 10 years.):				
A. Respiratory or lung disease, brain, nervous or mental disease, depression or anxiety, seizures or sleep apnea?	❑	❑	❑	❑
B. Liver disease, colitis, diabetes, sugar in urine, cancer, tumor, disease of the prostate, kidney or urinary tract?	❑	❑	❑	❑
C. High blood pressure, chest pain, heart disease, arrhythmia, stroke or other cardiovascular disease?	❑	❑	❑	❑
D. Back, bone or joint pain, arthritis, Alzheimer's or Parkinson's disease, muscular disease or paralysis?	❑	❑	❑	❑
E. Alcohol or drug problems? In Minnesota only, alcohol or drug problems within the past five years	❑	❑	❑	❑
F. Chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease? In Minnesota only, chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease within the past five years?	❑	❑	❑	❑
5. Has the proposed insured been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS or ARC? (In Wisconsin, the reporting of HIV tests is limited to the positive results of FDA licensed tests, and AIDS tests results obtained at anonymous counseling and testing sites are confidential and need not be disclosed)	❑	❑	❑	❑
6. During the past five years has the proposed insured used or do they now use barbituates, amphetamines, hallucinogens, marijuana, narcotics, cocaine or any prescription drug except by physician's prescription?	❑	❑	❑	❑
7. Has the proposed insured taken any prescription medication during the last 12 months?	❑	❑	❑	❑
8. Any other accident, injury, operation or medical attention within the past five years not stated above?	❑	❑	❑	❑
9. Has the proposed insured been unable to work during the past three years due to illness or accident? (Disregard minor non-recurring illnesses.)	❑	❑	❑	❑
10. During the past three years has the proposed insured been charged with three or more moving vehicle violations or during the past five years been convicted of a DWI or DUI?	❑	❑	❑	❑
11. Has the proposed insured taken any aerial flight other than as a fare-paying passenger on a commercial airline?	❑	❑	❑	❑
12. Does the proposed insured participate in any hazardous avocation, occupation or sport? (In Minnesota only, does the proposed insured participate in organized motorized racing events, scuba or sky diving, mountain or rock climbing?)	❑	❑	❑	❑
13. Has the proposed insured been convicted of or pled guilty or no contest to a felony in the past ten years?	❑	❑	❑	❑
14. Has the proposed insured had a parent or sibling die prior to age 60 due to heart disease, diabetes or cancer?	❑	❑	❑	❑
15. Do you have existing insurance or annuity contracts with this or any other company?	❑	❑	❑	❑
16. Is this insurance intended to replace existing insurance or annuity with this or any other company?	❑	❑	❑	❑
17. Does the proposed insured intend to travel outside the United States for reasons other than recreational purposes?	❑	❑	❑	❑

Explain any "YES" answers to the above questions. Provide details, dates, diagnosis, reason for prescriptions, etc.

_____

_____

_____

STATEMENT OF EARNINGS & OTHER INSURANCE ***(Complete if applying for over $500 Disability Income Benefits.)***

Earnings last year (A) $ _____
(B) $ _____

Earnings for prior year (A) $ _____
(B) $ _____

Other disability insurance in force? (A) ❑Yes ❑No
(B) ❑Yes ❑No

If yes, please provide details and identify by A or B.

Monthly Benefit	Benefit Period	Company
_____	_____	_____
_____	_____	_____

APPLICATION FOR CHILDREN'S COVERAGE

Children of the insured who have not reached their 19th birthday.

Name	DOB	Injury, illness or history of medical problems within the past 5 yrs.?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? In Missouri only, have any of these children applied or been examined for life, accident or health insurance that was modified as to rate or amount? Yes___ No___ If yes, give details.

Provide doctor's name and address._____

_____

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

PROPOSED INSURED A

Primary ❑ Revocable or ❑ Irrevocable
❑ Per Stirpes or ❑ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

Contingent ❑ Revocable or ❑ Irrevocable
❑ Per Stirpes or ❑ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

PROPOSED INSURED B (OTHER INSURED RIDER)

Primary ❑ Revocable or ❑ Irrevocable
❑ Per Stirpes or ❑ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

Contingent ❑ Revocable or ❑ Irrevocable
❑ Per Stirpes or ❑ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday_____
Address _____
_____

IRS Taxpayer Certification

Under penalities of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. United Life Insurance Company or its reinsurers may release information to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ Date _____

X_____ **X** _____

SIGNATURE OF PROPOSED INSURED A
(or parent if Proposed Insured is a minor)

SIGNATURE OF PROPOSED INSURED B
(or parent if Proposed Insured is a minor)

X_____ **X** _____

SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED A

I the agent, certify that to the best of my knowledge, the proposed insured ❑ does or ❑ does not have existing life policies or annuity contracts and that replacement ❑ is or ❑ is not involved in this transaction.

I the agent, certify that I have 1) used only insurer-approved or provided sales material, 2) left a copy of all sales material, 3) verified the identity of the owner/applicant.

X _____ _____

SIGNATURE OF AGENT — AGENT'S PRINTED NAME

_____ _____% _____ _____%

AGENCY NAME — AGENCY NUMBER — AGENCY NAME — AGENCY NUMBER

United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____ , 20 ____

the sum of $ _____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

(a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and

(b) all medical examinations, tests, electrocardiograms required by the Company must be completed within 60 days from the date of the application; and

(c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and

(d) with respect to any life insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding $100,000 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:
The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of $100,000 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.
If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

_____
(Signature of Agent)

United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance Company or its reinsurers may, however, make a brief report thereon to the *MIB, Inc., formerly known as Medical Information Bureau*, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is *50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.*

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

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Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

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Filing Company:	*United Life Insurance Company*	*State Tracking Number:*	*40593*
Company Tracking Number:	*LIU-113 (10-08)*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*LIU-113 (10-08)*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/15/2008

Comments:

Attachment:

AR Cert.pdf

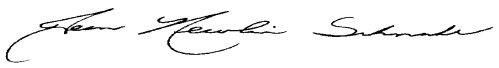
CERTIFICATE OF COMPLIANCE

UNITED LIFE INSURANCE COMPANY

Form number: LIU-113 (10-08) Application for Life Insurance

I hereby certify to the best of my knowledge and belief that this filing is in compliance with Arkansas Regulations 19 and 49 and Bulletin 11-88.

Certified by:



_____ 10/17/08_____

Jean Newlin Schnake, Secretary Date
United Life Insurance Company